TREATMENT PROTOCOL: NON-TRAUMATIC CARDIAC ARREST (ADULT) *

1. Basic airway
2. If arrest not witnessed by EMS:
   CPR for 2min at a compression rate of at least 100/min, minimize interruptions to chest compressions
3. Cardiac monitor: document rhythm and attach ECG strip
4. If asystole, confirm in more than one lead
5. If fine V-Fib is suspected, treat with V-Fib/Pulseless V-Tach

A 12-lead ECG shall be acquired on patients who complain of chest pain/discomfort of suspected cardiac etiology, non-traumatic post cardiac arrest patients with a return of spontaneous circulation (ROSC) and/or patients who the paramedics suspect are experiencing an acute cardiac event.

ASYSTOLE / PEA	V-FIB / PULSELESS V-TACH
6. If confirmed PEA, consider causes ❶ 7. Venous access, if unable: place IO (if available) 8. **Epinephrine** (1:10,000) ❹ 1mg IV or IO 9. Consider advanced airway ❷, capnography 10. If narrow complex and heart rate greater than 60bpm: **Normal saline** fluid challenge 10ml/kg IV or IO at 250ml increments 11. CPR for 2min 12. **CONTINUE SFTP or BASE CONTACT** 13. **Epinephrine** (1:10,000) 1mg IVP or IO May repeat every 3-5min 14. If down time greater than 20min: **Sodium bicarbonate** 1mEq/kg IV push May repeat 0.5mEq/kg every 10-15min 15. If resuscitative efforts are successful: Perform 12-lead ECG ❽ 16. If resuscitative efforts are unsuccessful and the patient does not meet ALL criteria for Termination of Resuscitation in Ref. No. 814, Section II.A., consult with the Base Physician ❼	6. Defibrillate ❺❻ Biphasic at 120-200J (typically) Monophasic at 360J 7. CPR for 2min 8. Venous access, if unable: place IO (if available) 9. Check rhythm ❸, and if indicated: Defibrillate Biphasic at 200J, monophasic at 360J 10. CPR for 2min 11. **Epinephrine** (1:10,000) ❹ 1mg IVP or IO 12. Consider advanced airway ❷, capnography 13. Check rhythm, and if indicated: Defibrillate Biphasic at 200J, monophasic at 360J 14. **CONTINUE SFTP or BASE CONTACT** 15. **Amiodarone** 300mg IV or IO 16. CPR for 2min 17. Check rhythm, and if indicated: Defibrillate Biphasic at 200J, monophasic at 360J 18. **Epinephrine** (1:10,000) 1mg IVP or IO May repeat every 3-5min 19. CPR for 2min 20. Check rhythm, and if indicated: Defibrillate Biphasic at 200J, monophasic at 360J 21. **Amiodarone** 150mg IV or IO Maximum total dose 450mg 22. CPR for 2min 23. Check rhythm, and if indicated: Defibrillate Biphasic at 200J, monophasic at 360J 25. If resuscitative efforts are successful: Perform 12-lead ECG ❽

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26. If resuscitative efforts are unsuccessful consult with the Base Physician ❼

SPECIAL CONSIDERATIONS

❶ Consider causes of PEA: acidosis; cardiac tamponade; drug overdose; hyperkalemia; hypothermia; hypovolemia; hypoxia; massive MI; pulmonary embolus; or tension pneumothorax
Drugs to consider for specific suspected causes:

If hypoglycemia is suspected:
DEXTROSE (50%)
50ml IV or IO

If narcotic overdose is suspected:
NARCAN (naloxone)
0.8-2mg IV or IO
2mg IN or IM

If dialysis patient:
CALCIUM CHLORIDE - BASE CONTACT REQUIRED
1gm IV or IO

SODIUM BICARBONATE – BASE CONTACT REQUIRED
1mEq/kg IV or IO

If tricyclic overdose suspected:
SODIUM BICARBONATE – BASE CONTACT REQUIRED
1mEq/kg IV or IO

If calcium channel blocker overdose suspected:
CALCIUM CHLORIDE – BASE CONTACT REQUIRED
1gm IV or IO

❷ Attempt to limit interruptions in CPR to no more than 10sec with advanced airway. Should utilize end tidal CO_2 monitoring for advanced airway and monitoring ROSC.

❸ Pulse check if a change in ECG rhythm, take no longer than 10sec to check for a pulse. If no pulse is detected within 10sec, resume chest compressions.

❹ If hypothermia is suspected, administer only one dose of epinephrine and **no other medications** until the patient is re-warmed

❺ Biphasic defibrillator settings may vary; refer to manufacturer's guidelines. If unknown, use 200J for biphasic, 360J for monophasic

❻ If hypothermia is suspected, defibrillate only once until the patient is re-warmed

❼ If hypothermia is suspected, resuscitation efforts should not be abandoned until the patient is re-warmed, or the base hospital orders termination of resuscitative efforts

❽ Post cardiac arrest patients with ROSC, with or without a 12 lead ECG analysis equivalent to "Acute MI", shall be transported to the most accessible open SRC if ground transport is 30 minutes or less regardless of service agreement rules and/or considerations.